Confidential Health Intake Form

Name ____
Street Address ____
City__________________ State_____ Zip___________________________
Date of Birth ____

Work Phone _______________________ Home phone_________________ Cell
Phone/pager______________

Emergency Contact ____

Employer ____
Social Security Number ____
Occupation ____

Referring Physician:____
Primary Care Physician:____

Insurance Information:

Was Injury a result of an accident?_________ If yes: Job related________
Auto ________ Other_________

Date of Injury or onset: ________________________
Referring Physician_____________________________

Insurance Company
Name:____
Billing Address:____
Phone Number:____
Contact person/ case manager _______________________________________

Name of Insured :____
Address:____
Phone:____

Group/Claim Number: ____

Attorney (if applicable)
Name :____
Address:____
Phone number: ____

I hereby authorize the release of medical information necessary to process my insurance claim. This may include intake forms, chart notes, reports, correspondences, billing

statements and any other information to my attorneys, health care providers and insurance case managers.

I am responsible for all charges for all services provided. In the event that the insurance company denies benefits or makes a partial payment, I am responsible for any balance due. This may not apply to insurance companies that I am under contract with.

I understand the benefits and risks of massage and give my consent for massage. I will consult my practitioner with any questions or concerns immediately.

I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.

I agree to provide **24 hour** cancellation notice. If I fail to do so, I agree to pay the **full** appointment fee. (Please note that insurance companies **do not** pay this, you do.)

Signature ____
Date ____

Medical History and Information

Check any or all that apply to your present health:

___ headaches ___chronic pain ___varicose veins

___ vision problems ___muscle or joint pain ___blood clots

___ sinus problems ___numbness/tingling ___high/low blood pressure

___ jaw pain/teeth grinding ___sprains/strains ___diabetes

___ fatigue ___scoliosis ___cancer/tumors

___ depression ___arthritis ___infectious disease

___ sleep difficulties ___tendonitis ___skin problems

Women only: Pregnant___ Painful menstruation___ endometriosis___

Men only: Prostrate problems___

List all medications/herbs/vitamins and dosage:
____

____

List physical activities you participate in
regularly____

Describe the events of the injury or accident:
____
____
____

List previous major injuries/surgeries:
____
____
____

What other treatments are you receiving and by whom (acupuncture, physical therapy, chiropractic, naturopathic):
____
____
____

What seems to help the most?
____

What seems to aggravate the condition the
most?____

What is your main activity at work? On phone ________ Sitting________ Computer work____________

Driving car_____________ Walking_____________
Other ____

What do you do to relieve stress____
____

Practitioner
Comments____
____
____
____
____